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December 28, 2012

John O'Brien
Director, Healthcare and Insurance
U.S. Office of Personnel Management
1900 E Street NW., Room 2347
Washington, D.C. 20415

Re: RIN 3206-AM47; 45 CFR Part 800; Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges; Proposed Rule

Dear Director O'Brien:

The Silver State Health Insurance Exchange appreciates the opportunity to comment on the proposed rules published by the U.S. Office of Personnel Management (OPM) in the Federal Register[1] on December 5, 2012 concerning the Multi-State Plan Program established pursuant to the Patient Protection and Affordable Care Act[2], as amended by the Health Care and Education Reconciliation Act of 2010[3], referred to collectively as the Affordable Care Act (ACA).

Our shared goal under section 1334[4] of the ACA is to increase competition on price and quality among qualified health plans participating in the Silver State Health Insurance Exchange by enabling individuals, families, and employers to select, *on a level playing field* in accordance with section 1324[5], health plans that will be available through the OPM alongside other Qualified Health Plans (QHPs)[6] available on our Exchange. Consistent with that shared goal, we seek to maintain appropriate oversight and control over the benefits and other requirements of Multi-State Plans to the extent that those plans will be offered through our Exchange and to ensure such plans do not create a competitive advantage or disadvantage over other plans that are available through the Silver State Health Insurance Exchange or the Nevada market in general. Additionally, we seek to minimize adverse selection and the resulting increases in premiums. To that end, we offer the following comments.

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[1] Federal Register, Vol. 77, No. 234, Wednesday, December 5, 2012, Proposed Rules, pp. 72582-72609
[2] Patient Protection and Affordable Care Act, H.R. 3590, Public Law 111-148
[3] Health Care and Education Reconciliation Act of 2010, H.R. 4872, Public Law 111-152
[4] Codified as 42 USC § 18054
[5] Codified as 42 USC § 18044
[6] Defined in 42 USC § 18021

45 CFR § 800.104 PHASED EXPANSION

We understand that, pursuant to 45 CFR § 800.104, the health insurance issuers not already providing nationwide coverage must agree to phase-in coverage for all states over a four year period (unless OPM decides to permit extensions). However, we do not expect that many health insurance issuers seeking to contract with OPM and seeking to participate in an Exchange will be unwilling or unable to meet that phase-in coverage requirement solely because they are required concurrently to meet other requirements of the Exchange.

We provide no opinion regarding whether health insurance issuers should be required by OPM to offer statewide coverage by the fourth year of participation in the Multi-State Plan Program (45 CFR § 800.104(b)). However, coverage in any service area must be contingent on the health plan providing adequate provider networks that meet or exceed the Exchange's and the State's network adequacy requirements, regardless of whether those standards are provided in State law or through policies issued by the Exchange.

45 CFR § 800.105 BENEFITS

By September 30, 2012, each State was required to select ***one*** benchmark plan to utilize as its set of Essential Health Benefits. As indicated in the Federal Register, the OPM has selected for its benchmark ***three*** Federal nationwide benchmark plans: Blue Cross-Blue Shield Basic Option, Blue Cross-Blue Shield Standard Option, and the Government Employees Health Association Standard Option. Pursuant to 45 CFR § 800.105(b)(1) of the proposed rule, a health insurance issuer contracting with OPM will select either one of the OPM benchmarks or the State's benchmark as a basis for benefits packages offered in the State. We are extremely concerned about this proposed regulation for the following reasons:

1. We do not believe that 42 USC § 18054 authorizes health insurance issuers to choose between the State's benchmark and the OPM benchmarks in the design of the plans that the issuers will offer through the Exchange.

2. Allowing a Multi-State Plan issuer to select one of four benchmarks could create a competitive advantage over other QHPs offered by an Exchange as other QHPs would not be afforded the same choice and that disparity among plans could result in adverse selection.

3. Following guidance provided by the Centers for Medicare and Medicaid Services (CMS) on December 16, 2011, Nevada conducted an extensive analysis of the ten benchmark plans with broad public input to determine the appropriate benchmark plan to be used as a basis for its essential health benefits. Nevada rejected the three federal plans as inappropriate for many Nevada consumers. Allowing a Multi-State Plan issuer to utilize the OPM selected benchmark in plans offered through State-operated Exchanges rejects the will of the States and is inconsistent with the theme, found throughout Title I of the

ACA, of federalism and delegation of insurance market and Exchange control at the State level.

All health insurances issuers offering plans through the Exchange, whether QHPs or Multi-State Plans, should follow the State's benchmark and coverage definitions.

45 CFR § 800.107 LEVELS OF COVERAGE

We would support permitting health insurance issuers, pursuant to 45 CFR § 800.107, to decide whether to participate in the Individual Exchange or the Small Business Health Options Program (SHOP) Exchange, if the State does not require issuers to participate in both. However, as stated in the discussion regarding 45 CFR § 800.114 (Compliance with State Law), if carriers are required by the Exchange to offer QHPs in both the Individual Exchange and SHOP Exchange, the Multi-State Plan issuer should be required to do the same.

Pursuant to 42 USC § 18054(c)(1)(B), we recommend 45 CFR § 800.107 be amended to permit Multi-State Plan issuers to offer catastrophic plans.

45 CFR § 800.108 ASSESSMENTS AND USER FEES

45 CFR § 800.108 (and 45 CFR § 800.114, concerning the responsibility of each Multi-State Plan Program issuer to comply with applicable State law) should be amended to explicitly state that a Multi-State Plan must pay all assessments and user fees charged by a State or Exchange. Such fees should include any assessment or user fee charged by the State for rate review or other oversight functions as well as any assessment or user fee charged by the Exchange for web portal shop and compare functions, eligibility, enrollment, call center operations, premium aggregation, billing, etc. The user fees required of any other QHP offered on the Exchange should be paid by the Multi-State Plan, regardless of whether those fees are provided in State law or through policies or contracts issued by the Exchange. If a Multi-State Plan is not required to pay the assessments and user fees generally charged to other QHPs, and the OPM does not adequately protect other QHPs from adverse selection, users may choose the Multi-State Plan in large numbers and the Exchange would not be able to cover its costs.

45 CFR § 800.108 contemplates charging assessments or user fees to Multi-State Plans for the services provided under 45 CFR Part 800 such as entering into contracts, certifying, recertifying, decertifying and overseeing Multi-State Plans. These services are duplicative of the processes that are being created by each Exchange and as such are inefficient. Any fee charged to a Multi-State Plan issuer over and above fees charged under the Federal Employees Health Benefits Program (FEHBP) will create a competitive disadvantage for the Multi-State Plans offered through the Exchange. Therefore, the OPM should be cautious when creating fees that do not align with the fees charged by the Exchange.

If OPM nevertheless seeks to impose fees over and above those already charged under the FEHBP, OPM should disclose in the Federal Register the actual, incremental costs that OPM

expects to incur as a direct result of the Multi-State Plan Program itself, as opposed to the FEHBP. It would not be appropriate for OPM to allocate a portion of FEHBP oversight costs to the Multi-State Plan Program.

45 CFR § 800.109 NETWORK ADEQUACY

45 CFR § 800.109 requires a Multi-State Plan issuer to meet general network adequacy requirements. Consistent with our discussion regarding 45 CFR § 800.114 (Compliance with State Law), we propose the Multi-State Plan issuer also be required to follow the network adequacy standards that all other QHPs that are offered in an Exchange are required to follow, regardless of whether those standards are provided in State law or through policies issued by the Exchange.

45 CFR § 800.111 ACCREDITATION REQUIREMENT

45 CFR § 800.111(c) requires a Multi-State Plan issuer become accredited within the time frame established by the OPM. We recommend the OPM utilize each State's selected accreditation timeframe for those States that are operating an Exchange. In no case should the timeframe for accreditation be longer than the State's timeframe.

45 CFR § 800.112 REPORTING REQUIREMENTS

In addition to the reporting requirements of the OPM, Multi-State Plan issuers should also be required to comply with the requirements of each Exchange.

45 CFR § 800.114 COMPLIANCE WITH APPLICABLE STATE LAW

45 CFR § 800.114 requires Multi-State Plan issuers to generally comply with State law to the extent that State law is not inconsistent with federal law. We agree that issuers must comply with State law. However, 42 USC § 18054(b)(2) states:

> "A health insurance issuer shall be eligible to enter into a contract under subsection (a)(1) if such issuer… is licensed in each State and is subject to ***all*** requirements of State law not inconsistent with this section, ***including the standards and requirements that a State imposes*** that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service or a requirement of this title." [emphasis added]

Therefore, we recommend the removal of the word "generally" (45 CFR § 800.114(a), first sentence) as the above requirement under the ACA to comply with State law is absolute, aside from any State requirement that might be inconsistent with or contradict federal law. We also recommend that the requirement to comply with State law include State regulations that have the force of law, policies adopted by the Exchange that apply to every other QHP offered through that Exchange, user fees and assessments charged to every other QHP offered through that Exchange and technical requirements necessary to place a QHP or Multi-State Plan on the Exchange for enrollment by qualified individuals, employers and employees. The law is very

specific that the Multi-State Plan must abide by the standards and requirements that a State imposes. A Multi-State Plan should not have a competitive advantage because it is exempt from the requirements placed on every other QHP offered in the Exchange. Furthermore, an Exchange should not be held hostage to the requirement that a Multi-State Plan be offered on an Exchange if such plan cannot meet the information technology requirements required of every other QHP.

45 CFR § 800.116 PROCESS FOR DISPUTE RESOLUTION

We do not support lengthy dispute resolution procedures such as those proposed in 45 CFR 800.116. We would welcome a memorandum of understanding approach that would stipulate more expeditious resolution of disputes (e.g., less than 14 days in 90 percent of the cases).

45 CFR § 800.203 MEDICAL LOSS RATIO

While we agree that a Multi-State Plan issuer must comply with the medical loss ratio requirements of section 2718 of the Public Health Services Act, we are concerned that decertification of a Multi-State Plan could have disastrous consequences if done mid-plan year. A mid-year decertification could create substantial harm to consumers who may be required to meet two deductibles due to forced migration to a new plan in the middle of the plan year.

45 CFR § 800.303 MSPP CONTRACTING

We are concerned that the proposed OPM rules, as currently written, do not provide adequate assurances that Multi-State Plans would conform to requirements of the Exchange. Multi-State Plans would not need to apply separately for certification through Nevada's Exchange because the plans will be deemed certified to be offered on all Exchanges pursuant 42 USC § 18054(d). Therefore, we request that OPM revise the proposed rules at 45 CFR § 800.303(f) to state unequivocally that Multi-State Plans must agree to the following stipulations regarding the Exchanges:

1) The plans shall comply with the State's essential health benefits package in its entirety and in the same manner as all other plans that will be offered on the Exchange.
2) The plans shall meet all requirements of State law (including State regulations that have the force of law and policy guidance that has been developed in accordance with such regulations) that are not inconsistent with the ACA.
3) The State shall have the sole authority to interpret State law.
4) The plans shall meet all technical requirements and specifications that are necessary to support the functionality of the Exchange.
5) The plans shall meet the same requirements as those that apply to all other qualified health plans under 45 CFR Part 155 and Part 156.

45 CFR § 800.404 COMPLIANCE ACTIONS

As stated above in the Medical Loss Ratio section, a mid-year decertification could create substantial harm to consumers who may be required to meet two deductibles due to the forced migration to a new plan in the middle of the year. 45 CFR § 800.404 should be clarified to indicate that a mid-year decertification is applicable to only the most egregious offenses; that actions such as those listed in 45 CFR § 800.404(b)(2)(iv) reduction of service areas, (v) withdrawal of certification, (vi) reduction of service areas and (vii) withdrawal of approval or termination of contract, should be timed to coincide with the end of the plan year.

We appreciate that OPM is seeking comments related to the need for effective coordination concerning issues such as network adequacy, premium rates, and timely dispute resolution between the Exchange and OPM. The Silver State Health Insurance Exchange can facilitate collaboration and transparency with OPM concerning all Nevada requirements and data sources, and we would welcome reciprocal transparency on OPM's part with Nevada concerning OPM requirements and data sources.

We appreciate the opportunity to offer these comments and look forward to working with you further on these and other health insurance exchange implementation activities.
Thank you very much for considering our input.

Sincerely,

Jon M. Hager
Director, Silver State Health Insurance Exchange

cc: Ann Wilkinson, Deputy Chief of Staff, Office of the Governor
Mike Willden, Director, Department of Health and Human Services
Scott Kipper, Commissioner of Insurance, Division of Insurance
Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services
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